Name and address of State Administering Agency, if different from the State Medicaid Agency.
The Ohio Department of Aging, 50 W. Broad Street, 8th Floor, Columbus, Ohio 43215

I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

A. X The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are: 42 CFR 435.217 and 435.236 Aged, Blind, Disabled.

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

B. _____ The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program.

C. X The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

Spousal impoverishment eligibility rules will be used.

Regular Post Eligibility

1. X SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a). Sec. 435.726--States which do not use more restrictive eligibility requirements than SSI.

1. Allowances for the needs of the:

(A.) Individual (check one)

1.____The following standard included under the State plan (check one):

(a) _____SSI
(b) _____Medically Needy
(c) _____The special income level for the institutionalized
(d) _____Percent of the Federal Poverty Level: _____%
(e) _____Other (specify):_____

2._____The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

3._ X _The following formula is used to determine the needs allowance:
Living in the community=65% of 300% of SSI payment standard

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):

1.____ SSI Standard
2.____ Optional State Supplement Standard
3.____ Medically Needy Income Standard
4.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
5.____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
6.____ The amount is determined using the following formula:
7._ X _ Not applicable (N/A)

(C.) Family (check one):

1.____ AFDC need standard
2.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4.____ The following percentage of the following standard that is not greater than the standards above:____% of_____ standard.
5. X The amount is determined using the following formula: For dependent family members when there is no community spouse, the AFDC payment standard for the number of dependent family members is reduced by the combined monthly income of the dependent family members.
6.____ Other
7.____ Not applicable (N/A)

(2). Medical and remedial care expenses in 42 CFR 435.726.

Regular Post Eligibility

2. ____ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) **42 CFR 435.735**--States using more restrictive requirements than SSI.

1. Allowances for the needs of the:
(A.) Individual (check one)
1.__The following standard included under the State plan (check one):
(a) _____SSI
(b) _____Medically Needy
(c) _____The special income level for the institutionalized
(d) _____Percent of the Federal Poverty Level: _____%
(e) _____Other (specify):
2.__The following dollar amount:
Note: If this amount changes, this item will be revised.
3.__The following formula is used to determine the needs allowance:

Note: If the amount protected for PACE enrollees in item 1 is **equal to, or greater than** the maximum amount of income a PACE enrollee may have and be eligible under PACE, **enter N/A in items 2 and 3.**

(B.) Spouse only (check one):

1._____The following standard under 42 CFR 435.121:

_____

2._____The Medically needy income standard

_____

3.____The following dollar amount: $_____

Note: If this amount changes, this item will be revised.

4 .____The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.

5._____The amount is determined using the following formula:

_____

_____

6._____Not applicable (N/A)

(C.) Family (check one):

1._____AFDC need standard

2._____Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.____The following dollar amount: $

Note: If this amount changes, this item will be revised.

4.____The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.

5.____The amount is determined using the following formula:

_____

_____

6.____ Other

7.____ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility

3.__X__State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a

community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a.) Allowances for the needs of the:

1. Individual (check one)

(A).____The following standard included under the State plan (check one):

1. _____SSI
2. _____Medically Needy
3. _____The special income level for the institutionalized
4. _____Percent of the Federal Poverty Level: _____%
5. _____Other (specify):_____

(B)._____The following dollar amount: $_____

Note: If this amount changes, this item will be revised.

(C)__X__The following formula is used to determine the needs allowance:

Living in the community=65% of 300% of SSI payment standard

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

_____
_____
_____

II. Rates and Payments

A. The State assures CMS that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

1.___ Rates are set at a percent of fee-for-service costs
2.___ Experience-based (contractors/State's cost experience or encounter date)(please describe)
3.___ Adjusted Community Rate (please describe)
4._X_ Other (please describe): The capitation rates were developed from base fee-for-service (FFS) data, My Care Ohio program data and adjustments underlying the PACE amount that would otherwise have been paid (AWOP). The PACE capitation rate development includes further adjustments to reflect the estimated distribution of nursing facility versus home and community-based service (HCBS) utilization and reduces the non-long-term services and supports component of the rate to reflect the expected impact of care management on services.

The following methodology is intended to meet the requirements specified in 42 CFR 460.182 regarding the prospective monthly capitation payments to a PACE organization for a Medicaid participant enrolled in PACE.

AWOP Methodology

PACE amounts that would otherwise have been paid (AWOP) are developed separately for the Medicaid Only PACE population and the Dual Eligible PACE population. The AWOP methodology differs between the two groups because the Medicaid Only population otherwise eligible for PACE receives services on a fee-for-service (FFS) basis; whereas, the Dual Eligible population otherwise eligible for PACE receives services through the MyCare Ohio managed care program. Consistent with the PACE Medicaid Capitation Rate Setting Guide, an updated calculation of the AWOPs will be prepared on an annual basis and will be calculated for a period no longer than 12 months. While the AWOP must be annually updated and trended to the appropriate 12-month period, a full rebasing of the data underlying the AWOP is only required every three years.

A full rebasing of the Medicaid Only AWOP is developed using updated historical FFS data for non-dual individuals ages 55 and over who reside in Cuyahoga County and meet the nursing facility level of care eligibility (proxy data). Whether or not a full rebasing occurs, the annual Medicaid Only AWOP calculation will reflect claims trend, updated aged-based normalization, and a revised projection of the assumed enrollment distribution between the Nursing Facility (NF) residents and Home and Community-Based Services (HCBS) recipients. The age-based normalization of the proxy data adjusts the experience to match the age distribution (ages 55-64 versus ages 65+) of the PACE population for both NF and HCBS recipients. For a consistent comparison, the AWOP methodology includes addition of projected patient liability amounts because the PACE capitation rates will be filed gross of patient liability (i.e. patient liability will ultimately be determined and administered on an enrollee-specific basis).

The Dual Eligible AWOP is calculated using the MyCare Ohio (MyCare) capitation rates as the base data. The MyCare data is an appropriate proxy because 100% of Dual Eligibles otherwise eligible for PACE are enrolled in the MyCare managed care program and, therefore, the full MyCare Ohio capitation rate would be paid for each recipient not enrolled in PACE. The Dual Eligible AWOP calculation further reflects aged-based normalization and projection of the assumed enrollment distributions between the Nursing Facility (NF) residents and Home and Community-Based Services (HCBS) recipients. The age-based normalization of the proxy data composites the age-banded MyCare Ohio capitation rates to match the age distribution (ages 55-64 versus ages 65+) of the PACE population for both NF and HCBS recipients. For a consistent comparison, the AWOP methodology includes addition of projected patient liability amounts because the PACE capitation rates will be filed gross of patient liability (i.e. patient liability will ultimately be determined and administered on an enrollee-specific basis).

PACE Capitation Rates Methodology

According to the PACE Medicaid Capitation Rate Setting Guide, the corresponding PACE capitation rates may be filed with an effective period of no less than one year, but no more than three years, and must be annually illustrated to be less than the corresponding twelve-month AWOP. To the extent that PACE capitation rates are filed for an effective period of more than one year, the capitation rates need to be filed at amounts lower than the projected AWOPs corresponding to each year of the of the effective period for the capitation. Although the final PACE capitation rates may result from negotiations with the provider and include consideration of actual PACE plan experience, a methodology similar to the AWOP methodology can be used to inform the rate negotiations.

Projected proxy data gross of patient liability should be categorized into two cohorts representing four data groups: (1) HCBS Waiver cohort (Dual Eligible and Medicaid Only enrolled in eligible HCBS); and (2) Nursing Facility population cohort (Dual Eligible and Medicaid Only nursing facility residents.) Because nursing facility utilization is expected to be lower for PACE program enrollees than for the composite PACE-eligible population, the proxy PACE capitation rates are developed assuming a PACE-specific mix of the HCBS Waiver cohort and the Nursing Facility population cohort costs. Additionally, composite utilization of non-long-term services and supports may be reduced to reflect the expected impact of care management on services. The PACE capitation rates are calculated and filed gross of patient liability because liability amounts will be determined and administered on an enrollee-specific basis.

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.
The Ohio Department of Medicaid (ODM) retained the services of an actuary (Milliman, Inc.) to assist with the development of the Program for All Inclusive Care (PACE) Medicaid capitation rates as well as the amount that would otherwise have been paid (AWOP) if individuals were not enrolled in PACE. All Milliman actuaries are members of the American Academy of Actuaries.

Medicaid rates are developed using actuarially sound methodologies. The development of the rate methodology is compliant with both the Medicaid capitation rate requirements set forth in 42 CFR 460.182 and with the PACE Medicaid Capitation Rate Setting Guide.

C. The State will submit all capitated rates to the CMS Regional Office for prior approval. The State assures that it will submit capitated rates to the CMS Regional Office for prior approval.

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State Medicaid Agency and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system.

The State Administrating Agency tracks all Medicaid-eligible enrollments and disenrollments in the State Medicaid Agency's integrated eligibility system, Ohio Benefits. Participant-specific enrollment and disenrollment information is transferred from Ohio Benefits to the State Medicaid Agency's claims payment system, Medicaid Information Technology System (MITS).

Medicare-only and private-pay-only PACE enrollments and disenrollment are tracked only in the State Administering Agency's internal data system,

On a monthly basis, the State Administering Agency makes a prospective payment to the PACE organization. The State Administering Agency also disseminates a list of PACE participants for which the PACE organization received payment during the month. Adjustments are made in the following month to account for participants who were disenrolled from the PACE program prior to the effective date of the payment.